NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 11, 2018

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Chinwe Offor, M.D.
[redacted]

Gerard A. Cabrera, Esq.
Bureau of Professional Medical Conduct
New York State Department of Health
90 Church Street, 4th Floor
New York, New York 10007

Diane Lufkin Schilling, Esq.
Napierski, Vandenburgh, Napierski & O'Connor, LLP
296 Washington Avenue Ext. Suite 3
Albany, New York 12203

RE: In the Matter of Chinwe Offor, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 18-201) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cmg
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF CHINWE OFFOR, M.D.	DETERMINATION AND ORDER 18-201

A Notice of Hearing and Statement of Charges were served on CHINWE OFFOR, M.D. ("Respondent"). A hearing was held on January 25, 2018 and March 22, 2018, at the offices of the New York State Department of Health ("Department"), 90 Church Street, New York, New York. Pursuant to § 230 of New York Public Health Law ("PHL") and New York State Administrative Procedure Act §§ 301-307 and 401, JILL RABIN, M.D., Ph.D., Chairperson, BRUCE WHITE, D.O., J.D., and RICHARD S. GOLDBERG, J.D., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. KIMBERLY A. O'BRIEN, ADMINISTRATIVE LAW JUDGE ("ALJ"), served as the Administrative Officer. The Department of Health, Office of Professional Medical Conduct ("Department") appeared by RICHARD J. ZAHNLEUTER, General Counsel, by CLAUDIA MORALES BLOCH, ESQ.[1] The Respondent was represented by DIANE LUFKIN SCHILLING, ESQ.[2] Evidence was received, witnesses were sworn and heard, and transcripts of the proceedings were made.

[1] Gerard A. Cabrera, Esq. will represent the Department post-hearing; Ms. Bloch retired in June of 2018.

[2] On or about January 19, 2018, Ms. Schilling, via email, appeared on behalf of Respondent and requested an adjournment to prepare for the hearing. Ms. Bloch strongly opposed the request to adjourn the hearing stating that the Department had been in discussions with Mr. Agwuebo, Respondent's former counsel, and Respondent for many months and both had been aware of the charges and the hearing for quite some time [ALJ Ex.3]. The Committee denied the adjournment request after considering the timing and reasons for the adjournment request and the Department's stated opposition to the request.

Procedural History

On or about December 21, 2017, the ALJ issued a Pre-Hearing Order and forwarded it to Ms. Bloch and Ike Agwuebo, Esq., Respondent's counsel at the time [ALJ Ex. 1]. The Pre-Hearing Order, among other things, set a date for the prehearing conference, January 24, 2018, and included the statutory requirements for filing a written answer "no later than ten days prior to the first day of hearing and any charge or allegation not so answered shall be deemed admitted" [ALJ Ex.1 at p.2-PHL§230(10)(c)(2)]. The Respondent through her counsel, Mr. Agwuebo, failed to file a timely written answer and the factual allegations and charges were deemed admitted. Accordingly, the factual allegations and eleven charges are sustained. Respondent committed professional misconduct, in violation of Education Law (Educ. Law): § 6530(3) – Practicing medicine with negligence on more than one occasion; § 6530(4) - Practicing medicine with gross negligence on a particular occasion;§ 6530(5) - Practicing medicine with incompetence on more than one occasion or with a lack of knowledge necessary to practice the profession; § 6530(6) – Practicing medicine with gross incompetence; and § 6530(32) – Failing to maintain an adequate medical record [Ex. 1].

Written Submissions:	June 4, 2018
Deliberations Held:	July 5, 2018 July 12, 2018

STATEMENT OF CASE

The charges having been deemed admitted, the Committee was required to determine only what penalty should be imposed on the Respondent.

FINDINGS OF FACT

The findings of fact were made by the Hearing Committee after a review of the record in this matter. The references in brackets refer to transcript pages [Tr.] and exhibits [Ex.]. The following findings of fact are the unanimous determinations of the Hearing Committee:

1. Respondent was licensed to practice medicine in New York on or about July 2, 1996, by the issuance of license number 203584 [Ex. 1, Ex. 2].
2. Respondent worked as a neonatologist at Mercy Medical Center ("Mercy"), Neonatology Intensive Care Unit ("NICU"), Rockville Center, New York, and provided care to Patients A-D, all were newborn babies ("newborns") [Ex. 3-6].
3. In December 2013, Mercy found that Respondent failed to meet professional standards and Respondent was put on focused review; her title of Assistant Director of Neonatology was taken away. Respondent has not practiced medicine in New York State since she was terminated from Mercy in August 2014 [Tr. 184-185, 196-197, 240-241].

DISCUSSION

While the charges were deemed admitted, the Hearing Committee considered the testimony of both the Department's expert, Jesus Jaile-Marti, M.D. ("Dr. Jaile"), and Respondent in reaching a determination about the appropriate penalty to impose. Dr. Jaile is a practicing neonatologist with 27 years of experience caring for newborns, and the Committee believes that he is well qualified to provide an opinion about the care Respondent has provided to her patients [Ex. 7]. He provided detailed testimony about Respondent's deviations from acceptable standards of care in her treatment of Patient A-D, all newborns [Tr. 1-152, Ex. 3-6]. A neonatologist ("neonatologist" or "clinician") has direct contact and responsibility for their patients and must understand the physiology of newborns. Respondent has significant and fundamental deficits in her fund of knowledge about the physiology

of newborns, and as a clinician it renders her unable to competently diagnose, assess, treat and manage her patients. Respondent incorrectly diagnosed her patients and ordered contraindicated medications and treatment. When her patient did not immediately respond to a treatment and or medication, Respondent would often quickly change course without a rationale for doing so. Respondent failed to recognize when it was necessary to consult with other providers who could provide assistance or better care for her patients and she did not recognize when to seek to transfer her patients to a facility that could provide needed care.

Respondent testified in her own behalf [Tr. 155-327]. Respondent had direct contact and responsibility for the care and management of her patients; it was evident to the Committee that she lacked awareness and understanding of her repeated and significant failures to meet acceptable standards of care. Respondent showed no remorse and was unwilling to accept responsibility for her actions. Respondent testified that she consulted with other providers and that these providers agreed with her treatment and management of her patients, but there was little or no information in the patient records about these consultations. Respondent also said that she met or exceeded acceptable standards of care in her treatment and management of her patients. However, Respondent's own testimony and the patient records clearly demonstrate that she did not meet acceptable standards of care.

CONCLUSIONS

The Committee believes that Respondent sincerely cares about her patients and their welfare, and they took note that she is academically accomplished [Ex. A; Tr. 160-161]. However, Respondent's failures as a clinician are significant and pervasive. The Committee in making a penalty determination seriously and carefully considered whether Respondent could safely practice medicine after completing another fellowship and extensive continuing medical education, and followed by a period of probation with a practice monitor ("retraining"). Ultimately the Committee

concluded that retraining would be futile given Respondent's adamant and unwavering defense of her actions, the number of years she has been practicing medicine, and that she showed no interest or willingness to receive training to improve her practice. Based on the foregoing, the Hearing Committee unanimously agreed that revocation is the only appropriate penalty to protect the people of the State of New York.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine is REVOKED; and

2. This Order shall be effective upon service on the Respondent in accordance with the requirements of PHL § 230(10)(h).

DATED: September 9th, **New York**
, 2018

[redacted]

Jill M. Rabin, M.D., Chairperson
Bruce D. White, D.O., J.D.
Richard S. Goldberg, J.D

TO: Chinwe Offor, M.D.

[redacted]

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New York State Department of Health
90 Church Street, 4th Floor
New York, New York 10007

APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

CHINWE OFFOR, M.D.

STATEMENT

OF

CHARGES

CHINWE OFFOR, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 2, 1996, by the issuance of license number 203584 by the New York State Education Department (NYED). Respondent is not currently registered with NYED for the practice of medicine.

FACTUAL ALLEGATIONS

A. Respondent undertook the care and treatment of Patient A (the identity of all patients herein charged is set forth in Appendix "A") in the Neonatal Intensive Care Unit ("NICU") at Mercy Medical Center ("Mercy"), Rockville Center, N.Y. from on or about the date of birth, September 15, 2013, through on or about September 18, 2013. Patient A was born at 38 weeks gestational age via induced vaginal delivery secondary to Intrauterine Growth Restriction ("IUGR"). Patient A was transferred to the NICU for IUGR, and for presumed sepsis, in light of premature rupture of membranes ("PROM"). On arrival in the NICU, Patient A's weight was 1997g. On or about September 18, 2013, Patient A was transferred to NY-Presbyterian – Columbia, Children's Hospital for Neonatal Diabetes Mellitus. Respondent's care and treatment of Patient A deviated from accepted standards of care in that Respondent:

1. Inappropriately diagnosed the patient as having hypernatremia and dehydration and started the patient on an aggressive hydration protocol.

2. Included sodium in the initiated aggressive hydration protocol, which was contraindicated.
3. Failed to timely treat the patient with the administration of insulin.
4. Failed to appropriately order an endocrine consult and/or to timely transfer the infant patient to another hospital center.
5. Failed to maintain a record that accurately reflects the care and treatment rendered the patient.

B. Respondent undertook the care and treatment of Patient B in the NICU at Mercy from on or about the date of birth, June 25, 2014, through on or about June 28, 2014. Patient B was identified as at risk for hypoglycemia based upon a maternal history of Gestational Diabetes. The infant patient was started on IV dextrose and, within approximately 3 hours from birth, Respondent ordered the addition of Calcium supplementation in the IV fluids. Thereafter, the IV site infiltrated, causing an IV burn, for which Respondent ordered the application of EMLA cream. Respondent's care and treatment of Patient B deviated from accepted standards of care in that Respondent:

1. Inappropriately ordered intravenous Calcium supplementation.
2. Inappropriately ordered the application of EMLA, which is contraindicated for an IV burn on an infant.
3. Failed to maintain a record that accurately reflects the care and treatment rendered the patient.

C. Respondent undertook the care and treatment of Patient C in the NICU at Mercy from on or about the date of birth, August 11, 2012 through on or about August 12, 2012 when the infant patient was transferred to Long Island Jewish Medical Center ("LIJ"). Patient C was transferred to the NICU for respiratory distress and a diagnosis of sepsis. A chest x-ray showed a small pneumothorax and an ECHO performed showed normal cardiac anatomy and a large Patent Ductus Arteriosum ("PDA"), which was small by day 2. The patient was given Indomethacin. The presenting respiratory distress progressed to Persistent Pulmonary Hypertension and the infant patient was transferred to LIJ in critical condition. Respondent's care and treatment of Patient C deviate from accepted standards of care in that Respondent:

1. Inappropriately ordered the administration of Indomethacin to close a PDA.
2. Inappropriately ordered the administration Fentanyl, causing decompensation, followed by ordering the administration of Naloxone (Narcan) and then Phenobarbital.
3. Inappropriately ordered the administration of Prostaglandin.
4. Inappropriately ordered frequent respiratory ventilator changes.
5. Failed to maintain a record that accurately reflects the care and treatment rendered the patient.

D. Respondent undertook the care and treatment of Patient D in the NICU at Mercy from on or about the date of birth, May 27, 2014 through on or about June 2, 2014. Patient D was transferred to the NICU for respiratory distress. Initial chest x-ray confirmed a right pneumothorax and the patient was placed on 100% oxygen via nasal cannula. A later chest x-ray showed a large right pneumothorax, consistent with a tension pneumothorax. Respondent inserted a chest tube, which remained in place for 3 days with the infant also remaining on NC 2L 100% Oxygen. Respondent's care and treatment of Patient D deviate from accepted standards of care in that Respondent:

1. Failed to wean the patient off 100% oxygen once the chest tube was placed and the pneumothorax evacuated.
2. Failed to maintain a record that accurately reflects the care and treatment rendered the patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

1. Paragraphs A, A.1 – A.5, B, B.1 – B.3, C, C.1 – C.5, D, D.1, D.2

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

2. Paragraphs A, A.1 – A.5, B, B.1 – B.3, C, C.1 – C.5, D, D.1, D.2

THIRD SPECIFICATON

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

3. Paragraphs A, A.1 – A.5, B, B.1 – B.3, C, C.1 – C.5, D, D.1, D.2

FOURTH THROUGH SEVENTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

4. Paragraphs A, A.1 – A.5

5. Paragraphs B, B.1 – B.3

6. Paragraphs C, C.1 – C.5

7. Paragraphs D, D.1, D.2

EIGHTH THROUGH ELEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

8. Paragraphs A.5

9. Paragraphs B.3

10. Paragraphs C.5

11. Paragraphs D.2

DATE: November 27, 2017
New York, New York

[redacted]

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct